KINCAID ♦ BRYANT
Consulting Engineers
A professional corporation

Mechanical • Electrical • Plumbing • Fire Protection • Value Engineering

P.O. Box 3478
Lynchburg, Virginia 24503

725 Church Street, 7th floor
Lynchburg, Virginia 24504

phone: 434-846-6510
fax: 434-846-0005

To: **All Document Holders**

From: **KINCAID ♦ BRYANT**

Date: January 28, 2008

Comm. No.: 07090

Project: Replace Kitchen Equipment at the Southern Virginia Mental Health Institute
Project Code: 720-10880-93-03

RE: **Addendum No. 1**

Gentlemen:

Enclosed for your information is a copy of Addendum No. 1, including changes and modifications to the Specifications and Drawings, for the above referenced project.

Please attach this addendum to all copies of the Contract Documents in your possession so that they may be brought up-to-date.

Acknowledgment of receipt of this addendum is required on the Bid Form.

Sincerely,
KINCAID ♦ BRYANT

David A. Kincaid, PE

Enclosure

KINCAID ♦ BRYANT
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Date: January 28, 2008

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Project: Replace Kitchen Equipment at the Southern Virginia Mental Health Institute
Project Code: 720-10880-93-03

RE: **Addendum No. 1**

At the time of submission of bids, written acknowledgment of receipt of this Addendum by the Bidder shall be made in the appropriate blank on the Bid Form.

This Addendum has been issued to all Document Holders on record with our office. Bidders shall see that all Sub-Contractors are properly notified of the applicable provisions herein.

The information in this Addendum supersedes any contradictory information or omission set forth in the Contract Documents, including all previous addendums.

End of ADDENDUM NO. 1

Addendum No. 1, dated January 28, 2008, to Bidding Documents for Replace Kitchen Equipment at Southern Virginia Mental Health Institute located in Danville, Virginia, Plans and Specifications dated January 11, 2008, K♦B File No. 07090, Project Code: 720-10880-93-03.

TO: PLAN HOLDERS OF RECORD

FROM: KINCAID ♦ BRYANT, Consulting Engineers
725 Church Street, 7th Floor
Allied Arts Building
Lynchburg, VA 24504

This Addendum forms a part of the Contract Documents and modifies the Plans and Specifications dated January 11, 2008, as noted below. Acknowledge receipt of this Addendum on the Bid Form. Failure to do so may subject Bidder to disqualification.

GENERAL

1. See attached Pre-Bid Conference Agenda, Pre-Bid Attendance List, Infection Control Program Plan and Plan Holders List.

END OF ADDENDUM NO. 1

Pre-Bid Conference

PROJECT TITLE: Replace Kitchen Equipment

PROJECT CODE: 720-10880-39-03

OWNER: Southern Virginia Mental Health Institute

LOCATION: Danville, Virginia

DATE/TIME: January 22, 2008 at 10:00 am

OWNER'S PROJECT MANAGER: Jim Taylor

A/E Firm: KINCAID ♦ BRYANT CONSULTING ENGINEERS

RECORD OF ATTENDEES: All attendees are requested to sign the Pre-Bid Conference "Record of Attendees" sign in sheet before the end of the conference.

THE FOLLOWING ITEMS SHALL BE COVERED:

INTRODUCTION of A/E and Agency Representatives

INVITATION TO BID

- Sealed Bids received by **DMHMRSAS** at the address listed in IFB.

- Bids will be opened and read aloud at **DMHMRSAS** at the same location.

INSTRUCTIONS TO BIDDERS

- **eVA Business Vendor Registration**: All bidders must be registered prior to award.

- **Conditions at the site**. If prospective bidders wish to re-visit the areas of the proposed work after today, they should contact **Buddy Sigmon** to arrange follow-up visit.

- **Bid Guarantee** of 5% is REQUIRED. Successful bidder will be required to submit Performance Bond & Standard Labor and Material Payment Bond regardless of contract amount.

- **Preparation and Submission of Bids:** Bidders must have a valid Virginia Contractor License No. to qualify as a bidder.

- **Receipt of Bids: Factors to take into account so your bid is on time:**

Security: Allow time for check-in at security desk.

Bid Officer must have bids in hand by date and time or they will be marked late and shall not be considered.

- **Building Permits:** Will be obtained by Owner. All other permits are the responsibility of Contractor.

PRE-BID QUESTION FORM

- All written questions must be submitted on the Pre-Bid Question form and faxed (add number) to the A/E no later than
- AE will respond to all pre-bid questions in the form of an Addendum and the Addendum will be faxed to you from
- If responses are in the Contract Document, the questions and responses will not be included in the Addendum.

BID FORM

- **Time for Completion** is 90 calendar days to completion from Notice to Proceed. Final Completion within 30 days after the date of Substantial completion.
- Bid Form shall be filled out completely and signed and dated.
- GENERAL CONDITIONS DGS-30-54 (CO-7) 10/05 Edition applies to this project.
- SUPPLEMENTAL GENERAL CONDITIONS DGS-30-376

REVIEW PROJECT REQUIREMENTS AND SPECIFICATION DIVISIONS

- Bidders shall carefully review all of the technical sections of the project manual.
- Access to work is limited to the work schedule of the facility – Construction work within the kitchen proper will be performed between 8:00 pm and 4:00 am. Work site will be clean each morning. Kitchen equipment shall be protected during construction hours. Work in Basement can be accomplished during normal work hours.
- Temporary Construction Facilities – None will be required. Contractor will be allowed to use toilet facilities in the Basement. A Construction trailer will not be required.
- Infection Control Issues – See attached SVMHI Infection Control Program Plan 2008.
- Security Issues – Construction badges issued by SVMHI will be required for all construction workers. A contractor orientation will be required. Orientation will be provided by SVMHI personnel.
- Water – Will be furnished by the Owner.
- Electricity - Will be furnished by the Owner.

- Sanitary - Will be furnished by the Owner.

- Other conditions or requirements included in the bid documents that should be called to the attention of the bidders.

GENERAL REVIEW OF DRAWINGS

- Review project site limitations and access – David Kincaid reviewed the project scope, drawings and specifications.

- Review the other aspects of the project.

- Discuss sequence of Construction – The contractor will not be allowed to remove all kitchen equipment at one time. The equipment will be replaced one piece of equipment at time. The kitchen will be operational each day.

QUESTION AND ANSWER PERIOD

- Responses to questions that may impact the scope of work and / or a bid price proposal must be made in an Addendum to the Bidding Documents. Responses that only involve finding information that is already in the Bidding Documents may be made verbally during this Q&A period.

- An addendum will be issued that will include these meeting minutes, any questions from the Pre-Bid Question form, and a copy of the attendee sign-in sheet.

VISIT TO THE AREAS OF THE PROPOSED WORK – The kitchen area and basement were toured.

COMMENTS:

- Kitchen equipment assembly is included in the project scope.
- All removed equipment becomes the property of the Contractor to remove the site and dispose of legally.
- There is no available storage within the facility. Contractor will need to provide storage trailers. An area on site will be designated for trailer parking.
- The cleaning of existing surfaces prior to the start of new work will be the responsibility of SVMHI.

PRE-BID CONFERENCE ATTENDEES
SIGN-IN SHEET

Company Name: KINCAID ♦ BRYANT, CONSULTING ENGINEERS General Contractor ( ) Subcontractor ( ) Supplier ( )

Address: 725 Church Street, 7th Floor, Lynchburg, Virginia 24503

Telephone Number: 434-846-6510 Fax Number: 434-846-0005

Attendee Name: David A. Kincaid Email: dkincaid@kbengineers.com

---

Company Name: DMHMRSAS General Contractor ( ) Subcontractor ( ) Supplier ( )

Address:

Telephone Number: 804-371-0307 Fax Number: 804-371-8898

Attendee Name: Jim Taylor Email: jim.taylor@co.dmhmrsas.virginia.gov

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Company Name: SVMHI General Contractor ( ) Subcontractor ( ) Supplier ( )

Address: 382 Taylor Drive, Danville, VA 24541

Telephone Number: 434-773-4255 Fax Number: 434-773-4262

Attendee Name: Marvin Sigmon Email: buddy.sigmon@svmhi.dmhmrsas.virginia.gov

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Company Name: SVMHI General Contractor ( ) Subcontractor ( ) Supplier ( )

Address: 382 Taylor Drive, Danville, VA 24541

Telephone Number: 434-793-4291 Fax Number:

Attendee Name: Leandra D. Gunn Email: leandra.gunn@svmhi.dmhmrsas.virginia.gov

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Company Name: SVMHI General Contractor ( ) Subcontractor ( ) Supplier ( )

Address: 382 Taylor Drive, Danville, VA 24541

Telephone Number: 434-773-4220 Fax Number: 434-773-4274

Attendee Name: Robin Crews Email: robin.crews@svmhi.dmhmrsas.virginia.gov

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Company Name: SVMHI General Contractor ( ) Subcontractor ( ) Supplier ( )

Address: 382 Taylor Drive, Danville, VA 24541

Telephone Number: 434-773-4229 Fax Number: 434-773-4274

Attendee Name: A. Wade Hopkins Email: wade.hopkins@svmhi.dmhmrsas.virginia.gov

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PRE-BID CONFERENCE ATTENDEES
SIGN-IN SHEET

Company Name: Moore's Electrical & Mechanical General Contractor (x) Subcontractor ( ) Supplier ( )

Address: Altavista, VA

Telephone Number: 434-309-2580 Fax Number: 434-369-7402

Attendee Name: David H. Allen Email: dallen@mooreselectrical.com

---

Company Name: Moore's Electrical & Mechanical General Contractor (x) Subcontractor ( ) Supplier ( )

Address: Altavista, VA

Telephone Number: 434-309-2562 Fax Number: 434-369-7402

Attendee Name: Garrett Shelton Email: gshelton@mooreselectrical.com

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Company Name: _____ General Contractor ( ) Subcontractor ( ) Supplier ( )

Address: _____

Telephone Number: _____ Fax Number: _____

Attendee Name: _____ Email: _____

Company Name: _____ General Contractor ( ) Subcontractor ( ) Supplier ( )

Address: _____

Telephone Number: _____ Fax Number: _____

Attendee Name: _____ Email: _____

Company Name: _____ General Contractor ( ) Subcontractor ( ) Supplier ( )

Address: _____

Telephone Number: _____ Fax Number: _____

Attendee Name: _____ Email: _____

Company Name: _____ General Contractor ( ) Subcontractor ( ) Supplier ( )

Address: _____

Telephone Number: _____ Fax Number: _____

Attendee Name: Email: _____

X:\Shared\Forms\prebid conference attendees sign in sheet

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL PROGRAM PLAN 2008

The Infection control Program Plan has been revised and updated in January of 2008 by the Infection Control Committee to reflect current recommendations from the Center for Disease Control and Epidemiology, and in the light of the evolving environment of Southern Virginia Mental Health Institute. It contains program management as well as clinical management guidelines for the control of healthcare-acquired infections at this Institute

Reviewed/Revised By: Carlos de Aristizabal
Chairperson, Infection Control Committee

Reviewed/Revised By: Carlos de Aristizabal
Chairperson, Institute Instruction Review

Approved By: David M. Lyon,
Director

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL PROGRAM PLAN 2008

Table of Contents

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter One

Maintaining An Effective Program

The Institute maintains an effective program for the surveillance, prevention and control of infection that is interdisciplinary, inter-departmental, and hospital-wide. The program contains a systematic plan that reduces the risk of healthcare-acquired infections for patients, staff, and visitors. The program is guided by the Infection Control Committee and encompasses all patient care and support services and departments.

Southern Virginia Mental Health Institute's plan provides ongoing monitoring of healthcare-associated infections, implements prevention measures, provides patient and staff education, initiates measures to minimize the impact of those infections that do occur, and evaluates the effectiveness of such measures.

Evidence-based guidelines from the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA), Food and Drug Administration (FDA), State and Local regulations, and scientific literature form the basis for the standards of practice for the program.

1) All services and departments work cooperatively with the Infection Control Program Manager to develop infection control policies for their area of responsibility. Departments that develop appropriate department-specific infection control policies and procedures are: Administration, Nursing, Medicine, Environmental Services, Dietary, Plant Maintenance, Volunteers, Materials Management, and Pharmacy.

2) All relevant services and departments establish written policies and procedures that describe the role and participation of their employees in infection prevention and control. Special emphasis is placed on the management of those risk factors, as identified in Chapter Fourteen.

3) This plan has established written policies and procedures that describe the role and scope of participation of employee health activities in the infection control program. The Infection Control Program Manager participates in the decision making process that determines the content and scope of any employee health activities.

4) Employee health activities include monitoring and management of tuberculosis infections, prevention of the spread of blood-borne pathogens, and the surveillance of the incidence of infections in the work-force.

5) The Infection Control Program staff will be qualified to oversee the infection control process. Their qualifications may be met through

A) education;
B) training;
C) experience
D) certification or licensure. (Certification by the Certification Board for Infection Control CBIC I is desirable.)

6) Activities aimed at preventing infections in patients and staff include:

A) Vaccinations and screening/testing for infectious diseases of epidemiological significance to the facility such as tuberculosis, influenza and exposure to blood-borne pathogens.
B) Staff are provided with approved personal protective equipment, engineering controls, medical supplies and devices that are consistent with current medical practice.
C) Infection control education and training is provided for all staff upon initial employment, whenever duties/tasks with infection-related risks are assigned and annually thereafter. Additional infection control educational programs shall be provided when identified to meet the needs of patients or staff .

7) Control Measures

Appropriate control measures are used to prevent the initial or further spread of infections. These measures include:

A) Education of patients and staff,
B) Isolation of affected patients,
C) Culturing of the environment, patients, and staff if indicated,
D) Cohorting patients and staff during an outbreak, when feasible,
E) Restriction of affected staff from the facility during infectious periods,
F) Appropriate placement of patients with communicable/transmissible diseases,
G) Appropriate and timely treatment of infections.
H) Maintenance of current action plans for outbreaks of infections, including those caused by acts of bio-terrorism.

8) The Infection Control Program shall be evaluated annually by the Infection Control Committee.

Written: June 1995; revised 9/96; 8/97; 7/99; 2/00; 6/01; 4/02; 2/03; 1/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE

INFECTION CONTROL

Chapter Two

Procedures To Ensure Surveillance

All relevant services and the Infection Control program staff will carry out procedures to ensure that surveillance is maintained to monitor the rates of healthcare acquired infection, that systems are present to collect and analyze data, and that activities are conducted to prevent and control infection.

1) The Institute will conduct a comprehensive system of surveillance. The infection control program staff will monitor interventions from the clinical staff ensuring that timely and effective infection control measures are used.

2) Surveillance will take place by the use of several vehicles including:
   A) Formal reporting mechanism for all patient-related infections using the SVMHI intranet reporting system.
   B) Formal reporting mechanism for all staff-related infections using form SVMHI #74A.
   C) Daily unit reports to the Director of Nursing through form SVMHI # 18
   D) Antibiotic dispensing notification from the pharmacy on form SVMHI # 73A
   E) Cumulative microbiology report from the pathology laboratory.
   F) Unit rounds.
   G) Chart reviews.
   H) Environmental surveillance rounds conducted by the Environment of Care Committee and performed quarterly in all areas.

3) Epidemically important issues include:
   A) device-related infections, especially those associated with
      I) tube feeding
      II) urinary catheters
   B) wound infections;
   C) infections caused by organisms that are antibiotic-resistant;
   D) tuberculosis and other communicable diseases,
   E) Blood-borne pathogens.

4) The Infection Control Program Manager will make determination as to the class of infection, healthcare acquired or community acquired, for all infective processes that are reported in patients.

5) Since Institute patients have frequent access to the community throughout their hospitalization, the Infection Control Program Manager will use clinical judgment to classify infections as healthcare acquired infections or community acquired infections.

Determination will be based on incubation period, time lapsed since admission, patient's access to the community since admission, microbiological studies, clustering, and other clinical data.

6) The Infection Control Program Manager will prepare surveillance data for review by the Infection Control Committee.

7) The Infection Control Committee will consider during the data review:
   A) Infections that are a result of unusual pathogens.
   B) Clusters of infections.
      Culture sensitivity/resistance studies as relevant.
      Healthcare acquired infections that exceed baseline levels.
      Infections related to epidemic potential.
   C) The Infection Control Program Manager will prepare and present summary data of the following rates:
      A. Healthcare acquired infection of patients per 1000 patient/days.
      B. Staff infections occurring per 100 Full-time-equivalents (F.T.E.)

8) The Infection Control Committee will use as baseline levels rates that lie at either side of three standard deviations from data collected in the previous twelve months.

9) Reportable infections will be reported to the Public Health authorities as required by law.

Written: June 1995; revised 9/96; 8/97; 7/99; 2/00; 6/01; 4/02; 2/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Three

Infection Control Program Staff

The Infection Control Program will be implemented by staff who have a special interest or knowledge in infection control. Infection Control Program Manager will have received training by the Association of Practitioners in Infection Control, the North Carolina Statewide Infection Control Program (SPICE,) or other appropriate sources. The Infection Control Program Manager reports on the activities of the Infection Control program to the Infection Control Committee

1) PROCEDURE:

2) As it may be indicated, the Infection Control program will include in its function staff from medicine, food service, environmental services, or pharmacy, as needed to carry out its functions.

3) The Infection Control Committee is responsible for data evaluation, and review and approval of all policies and procedures relating to infection control. The Infection Control Program Manager has the authority to approve Infection Control program policies and procedures on behalf of the Committee.

4) The Infection Control Committee will review:
   A) Trends for the previous year for data collected regarding infections in patients, infections in staff.
   B) The effectiveness of infection control measures in reducing healthcare acquired infections.

Written: June 1995; revised 9/96; 8/97; 7/99; 2/00; 6/01; 4/02; 2/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Four

Authority to Evaluate and Request Corrective Action

The Infection Control Program Manager and, in his absence other infection control staff, has the authority to evaluate and request corrective action of problems impacting on Infection Control.

1) PROCEDURE:

2) The authority to make final decisions on Infection Control matters that because of their urgency cannot be handled through the committee process is vested on the Chairman of the Infection Control Committee.

3) The Infection Control Program Manager has the authority to order appropriate measures of infection control until a final decision is rendered by the Chairman of the Infection Control Committee.

Written: June 1995; revised 9/96; 8/97; 7/99; 2/00,6/01; 4/02; 2/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Five

Infection Control Program Staff Competence

The Infection Control Program staff will maintain competence by continuing education activities in infection control, as evidenced by attendance at Infection Control educational programs presented by the DMHMRSAS Infection Control Quality Circle, the Association of Practitioners in Infection Control (APIC,) the North Carolina Statewide Program for Infection Control and Epidemiology (SPICE) program, and supplementary experiences.

Attached: Job descriptions
Written: June 1995; revised 9/96; 8/97; 7/99; 2/00; 6/01; 4/02; 2/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Six
Personnel Expertise Pertaining to Infection Control

All personnel will maintain expertise pertaining to infection control procedures, as evidenced by attendance at educational programs and performance review.

1) PROCEDURE:

2) All personnel will receive orientation pertaining to infection control. This orientation will take place in the first thirty days of employment.

3) All personnel will attend educational programs appropriate to their responsibilities so they can maintain competence in infection control procedures, and to maintain awareness of the importance of infection control.

4) Staff Development and Nursing Education will maintain a file describing the content of all educational programs in infection control and participation of staff in such programs.

Written: June 1995; revised 9/96; 8/97; 7/99; 2/00; 6/01; 4/02; 2/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Seven

Use of Sterile Items

All departments and services that store or use sterile items will ensure at the point of use that their sterility is uncompromised, and develop policies and procedures to guide performance.

1) PROCEDURE:

2) Policies must address the storage life of all items.

3) Sterilizing equipment will not be used. Only supplies that are sterilized by an original manufacturer will be used.

4) No item meant by the manufacturer to be disposable will be re-used for purposes that require sterility.

Written: June 1995; revised 9/96; 8/97; 7/99; 2/00; 6/01; 4/02; 2/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE

INFECTION CONTROL

Chapter Eight

Coordination of Activities with the Danville-Pittsylvania Health Department

The Infection control program will coordinate activities with the Danville-Pittsylvania Health Department to address infections that have community-wide implications.

1) PROCEDURE:

2) All staff for whom vaccinations for hepatitis are being considered will be referred to the Danville-Pittsylvania Health Department for administration of the Vaccine, as appropriate, at Institute expense.

3) All staff who are in need of evaluation as a result of the Institute's tuberculosis screening program will be referred to the Danville Regional Medical Center Occupational Health Service for evaluation and treatment.

4) The Institute physicians will ensure all the requirements are met in regards to reportable disease to the Danville-Pittsylvania Health Department.

5) The infection control program manager will communicate with the office of epidemiology of the Danville-Pittsylvania Health Department when there may be reason to suspect an unusual and serious clustering of infections is taking place.

6) Southern Virginia Mental Health Institute will cooperate with the Danville-Pittsylvania Health Department in the management of outbreaks of infections.

Written: June 1995; revised 9/96; 8/97; 7/99; 2/00: 6/01; 4/02; 2/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Nine

Guidelines For Patients Suspected Of Having Influenza

The following guidelines should be used for patients suspected of having influenza.

Symptoms

- Fever of 101° to102° generally lasts 3-5 days, and is often higher in the afternoons and evenings, with some decrease in the mornings. Fever typically runs higher in children and can be over 104°.
- Cough starts as dry and hacking and progresses by the 3rd day to wet with thick mucous. The cough can worsen for the next 4-7 days and could last for over 2 weeks. This is the major symptom of influenza.
- Smokers are at risk for significant bronchitis and pneumonia.
- Headaches and muscle aches can be severe for the first few days and will slowly improve.
- Fatigue is common and severe, lasting for 1-3 weeks.
- Sore throat is most common in older children and adults. It can be severe for the first few days.
- Nasal congestion lasts for 1-2 weeks, and eyes may be red for 3-4 days.
- Vomiting or diarrhea is unusual in adults. These symptoms are typically seen in children less than 6 years of age and last for the first few days.
- Influenza is typically contagious for 5-7 days from fever onset.

General Treatment

- Give medicines such as acetaminophen, ibuprofen, or aspirin for fever, muscle aches and headaches.
- Give plenty of fluids to prevent secretions from getting thick and increasing breathing problems.
- Provide rest to help the body fight the infection.
- Antibiotics are of absolutely no use for influenza and are used only for bacterial complications after the acute phase is over.

Specific treatment

- Specific treatment may be indicated if symptoms are observed and treatment started in the first 48 hours of occurrence.
- Send throat swab to DRMC or LabCorp for rapid test for influenza. Test is done Monday to Friday only, with a report sent the following day. Cost is $52.00
- If throat swab is positive for influenza A or influenza B, give Tamiflu 75 mgm BID for five days. Cost is $44.00 for the ten capsules.
- Expect the illness to be shortened by 1 to 2 days.

Written: June 1995; revised 9/96; 8/97; 7/99; 2/00; 6/01; 4/02; 2/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Ten

Guidelines for the Management of Multi-Drug Resistant Organisms

SVMHI clinicians will make use of these guidelines for the management of of Multi-Drug Resistant Organisms

1) **Background:**
   A) Antimicrobial agents are losing their effectiveness for a wide range of community and hospital acquired pathogens, including enterococcus and staphylococcus. This is a prevalent healthcare acquired pathogen in the United States.
   B) The Centers for Disease Prevention and Control, CDC, has established guidelines for managing resistance in acute care settings. In MH/MR setting where active treatment and reintegration into the community is the goal these guidelines need to be modified.
   C) This policy establishes guidelines for the care and treatment of patients infected or colonized with resistant organisms while maintaining a safe and sanitary environment for all patients and staff.

2) **Definitions:** (As defined by the CDC)
   A) Colonization – the organism is present in or on the body, but is not causing illness.
   B) Infection – organism is present and is causing illness.
   C) Multi-drug resistant organism – An organism that is resistant to 2 or more unrelated antibiotics to which the organism is normally considered susceptible.
   D) Personal Protective Equipment (PPE) – Protective clothing such as gowns, gloves masks and eye shields.
   E) Standard Precautions – A system of barrier techniques and practices used by HCW designed to reduce the risk of transmission of infectious agents. This system applies to all patients regardless of their presumed infection status. (gloves, handwashing, other PPE as required.)
   F) MRSA – Methicillin resistant Staphylococcus aureus.
   G) VRE – Vancomycin resistant Enterococcus.

3) **Specific Guidance:**
   A) Transmission
      I) Hospital personnel can pass on, and may harbor, the organism for many months. They have been commonly identified as a link for transmission of infection between patients..
      II) The main mode of transmission is via hands (especially Health Care Workers' hands)
      III) infected patient contact, infected staff sites, device, items, or environmental surface contamination.

B) Assessment:
   I) All colonized/infected patients will be evaluated on an individual basis to determine the need for additional precautions.
   II) Routine admission cultures are not recommended.
   III) Cultures will be obtained when there is indication for doing so.

C) Procedures:
   I) All patients will be managed using Standard Precautions.
   II) Additional precautions require a physician's order and consultation with Infection Control.
   III) Standard Precautions and consistent hand-washing are to be used at all times for the management of multi-drug resistant organisms. Always use Standard Precautions when dealing with any patient (hand washing, gloves, masking, gowning, and appropriate handling of devices and laundry).
   IV) Contact precautions include:
      (a) Additional personal protective equipment is to be used as indicated.
      (b) Place the patient in a private room. When not available, patients maybe placed in a room with patients who also has active infection of the involved organism.(cohorting)
      (c) Wearing gloves when entering the room.
      (d) Wearing a gown when entering the room.
      (e) Limiting movement and transportation of the patient.
      (f) Ensuring patient care items and room is cleaned daily.
      (g) Limiting equipment used on infected patient to that patient only.
   V) Cleaning equipment thoroughly between patients to prevent cross infection.
   VI) Dedicating specific Health Care Workers to provide one-to-one care for that infected patient or patients.
   VII) Treating with appropriate antibiotic identified by laboratory sensitivity studies.

4) Colonized patients:
   A) Patients who are identified as colonized, but not actively infected do not need to be isolated.
   B) The patient should be placed in a private or single room.
      I) If not available, the patient should be placed in a room with another patient who is colonized with the same organism and no other infection (cohorting).
      II) If that is not possible, then the patient should be placed in a room with a person without chronic, underlying medical conditions, open wounds or invasive devices. Other factors to consider in roommate selection include, mobility of patients, containment of infected body fluids, ability of patients to understand and follow good handwashing and hygiene practices.
      III) In general, patients who are colonized with resistant organisms may use common living areas, recreational facilities and dining rooms.
      IV) VRE colonized patients should wear diapers if incontinent of stool.

5) Infected patients:

A) The patient should be placed in a private or single room.
   I) If not available, the patient should be placed in a room with another patient who is infected or colonized with the same organism and no other infection (cohorting).
   II) If that is not possible, then the patient should be placed in a room with a person without chronic, underlying medical conditions, open wounds or invasive devices provided that the infected site can be kept covered. Other factors to consider in roommate selection include, mobility of patients, containment of infected body fluids, ability of patients to understand and follow good handwashing and hygiene practices.
   III) In general, patients who are infected with resistant organisms may use common living areas, recreational facilities and dining rooms.
   IV) Patients should have clean dry dressings on open wounds, wear clean clothing, and be encouraged to perform proper handwashing techniques.
   V) VRE infected patients should wear diapers if incontinent of stool.

6) Culturing:
   A) Routine aggressive culturing of patients is not recommended.
   B) Cultures will be obtained when there is a clinical indication for doing so.

7) Treatment:
   A) To be determined by the treating physician who may consult with the infection control practitioner.
   B) Eradication of MRSA colonization in patients is generally not recommended and may contribute to further development of antibiotic resistance.

8) Discontinuation of Contact Precautions:
   A) The following criteria are required to consider a patient free of colonization or infection ("cleared").
   B) Three consecutive sets of negative cultures within a week, obtained after antibiotic therapy has been discontinued for a minimum of 72 hours in the absence of a draining wound, profuse respiratory secretions, or evidence implicating the specific organism.
   C) Culture sites include a perirectal swab for VRE and cultures of the original site, colostomy or and/open wounds for MRSA.
   D) Reference: CDC MDRO Guideline 2006
   http://www.cdc.gov/ncidod/dhqp/pdf/ar/MDROGuideline2006.pdf

Written: June 2000; revised 6/01; 4/02; 2/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Eleven

Guidelines for the Management of Patients Suspected of Having Pulmonary Tuberculosis

Background:
Pulmonary Tuberculosis (TB) is a significant threat to the health of people confined to institutional settings. Because of the relative lack of symptoms of the incipient disease, screening by means of modified Purified Protein Derivative (PPD) should be done on all patients with risk factors. On admission, all patients should be evaluated by a health care professional to ascertain if any pulmonary symptoms present may be caused by the infective agent of TB, mycobacterium tuberculosis.

Risk factors

- Risk factors for TB include:
- Contacts to active or suspected pulmonary or laryngeal tuberculosis cases.
- HIV infection or AIDS.
- Silicosis.
- Diabetes Mellitus
- Steroid therapy.
- Immunosuppressive therapy.
- Leukemia.
- Hodgkin's disease.
- End-stage renal failure.
- Intestinal bypass.
- Recent gastrectomy.
- Chronic malabsorption syndrome.
- Cancer.
- Body weight 10% ideal.

Signs and symptoms of pulmonary TB

- Progressively increasing cough over weeks or months.
- Mucoid or mucopurulent sputum.
- Anorexia.
- Weight loss.
- Fatigability.
- Hemoptysis.
- Fever.

- Chills.
- Myalgia.
- Sweating.
- Physical findings of rales or lung consolidation.

Transmission

Hospital personnel can pass on, and may harbor, the organism for many months. They have been commonly identified as a link for transmission of infection between patients and staff. The main mode of transmission is via airborne particles produced when an infected individual coughs, sneezes, speaks or sings.

Precautions and treatment

In addition to Standard Precautions when dealing with any patient (hand washing, gloves, masking, gowning, and appropriate handling of devices and laundry) staff should place the person suspected of having pulmonary TB in a room with negative air pressure and encouraged to wear a surgical face-mask until transported to a treating facility. Negative pressure is available in each seclusion room and in the admission waiting room.

Patients suspected of having active pulmonary TB are unsuitable for treatment at this facility. They should be transferred to Danville Regional Medical Center with whom an agreement exists for the treatment of such patients. Such transfer should be accomplished immediately. Staff should contact the facility Director's office to invoke the agreement. Pending such transfer, patients will be assigned to any of the seclusion rooms, where negative air pressure is present.

Transportation to DRMC

A transportation team has been organized to effect transportation and have been fitted to wear HEPA compliant respiratory protection during the transportation procedure. Members are:

- Director of Nursing.
- Clinical Nurse Specialist.
- Facility Director.
- Quality Manager.

Written: 6/00; revised 6/01/; 4/02; 1/03; 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Twelve

Guidelines for Handwashing

Recommendations

1. Indications for handwashing and hand antisepsis are adapted from the Guidelines of the Center for Disease Control. Ref:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm

A. When hands are visibly dirty or contaminated with protein material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water (IA) (66).
B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. Alternatively, wash hands with an antimicrobial soap and water in all clinical situations.
C. Decontaminate hands before having direct contact with patients.
D. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure.
E. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient.)
F. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled.
G. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care.
H. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.)
I. Decontaminate hands after removing gloves.
J. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water.
K. Antimicrobial-impregnated wipes (i.e., towelettes) may be considered as an alternative to washing hands with non-antimicrobial soap and water. Because they are not as effective as alcohol-based hand rubs or washing hands with an antimicrobial soap and water for reducing bacterial counts on the hands of HCWs, they are not a substitute for using an alcohol-based hand rub or antimicrobial soap.
L. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if exposure to *Bacillus anthracis* is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores.

2. Hand-hygiene technique

A. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry . Follow the manufacturer's recommendations regarding the volume of product to use.
B. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis.
C. Liquid, bar, leaflet or powdered forms of plain soap are acceptable when washing hands with a non-antimicrobial soap and water. When bar soap is used, soap racks that facilitate drainage and small bars of soap should be used.
D. Do not add soap to a partially empty soap dispenser. This practice of "topping off" dispensers can lead to bacterial contamination of soap.
E. Use hand lotions or creams to minimize the occurrence of irritant contact dermatitis associated with hand antisepsis or handwashing.

6. Other Aspects of Hand Hygiene

A. Keep natural nails tips less than 1/4-inch long.
B. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and nonintact skin could occur.
C. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients.
D. Change gloves during patient care if moving from a contaminated body site to a clean body site.

Written 1-15-03
Revised: 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Thirteen

Guidelines for the Management of Tinea Pedis

Background:
Tinea pedis is most commonly caused by *Trichophyton rubrum*, a dermatophyte fungus that invades the superficial keratin of the skin.
The cutaneous presentation is dependent on the host's immune system, as well as the infecting dermatophyte. *Candida albicans* can complicate the process, as can bacteria. A hot, humid, tropical environment and prolonged use of occlusive footwear are risk factors for all types of tinea pedis. Certain activities, such as swimming and communal bathing, also may increase the risk of infection.

History:
Patients complain of pruritic, scaling soles of the feet, often with painful fissures between the toes. Less often, patients may describe vesicular or ulcerative lesions. Some patients, may have no complaint at all and attribute their scaling feet to dry skin.

Physical:

- Interdigital
  - The interdigital presentation is the most characteristic type of tinea pedis, with maceration, fissuring, and scaling, most often between the fourth and fifth toes.
  - Usually the dorsal foot is clear, but some extension may occur onto the plantar surface of the foot.
- Moccasin or chronic hyperkeratotic
  - Chronic asymptomatic or pruritic erythema with slight scaling. Usually both feet are involved.
  - The dorsal foot typically is clear. In severe cases, some involvement may extend onto the sides of the foot.
- Inflammatory or vesicular
  - Painful, pruritic vesicles or bullae, most often on the instep or anterior plantar surfaces.
  - The lesions can contain either clear or purulent fluid; after rupture, scaling with erythema persists.
  - A similar eruption may develop on the palmar surface of one or both hands and/or the sides of the fingers. Papules, vesicles, and occasionally bullae or pustules may occur. This is a dermatophytid response to the infection on the foot, and contains no fungal elements.
- Ulcerative
  - Rapidly spreading vesiculopustular lesions accompanied by a secondary bacterial infection.

- Cellulitis, lymphangitis, pyrexia, and malaise can accompany this infection.
- Occasionally, large areas, even the entire sole, can be sloughed.

Lab Studies if indicated:

Direct examination of skin scrapings under a fluorescent microscope.
Fungal culture can be performed to confirm the diagnosis and identify the pathogenic species..

Patient's instructions and precautions

Infection can occur through contact with infected scales on bath shower floors
Shower-type footwear in communal areas may decrease the likelihood of transmission.
Infected scales also may be present on clothing. Frequent laundering is encouraged.
Encourage good foot hygiene to minimize foot moisture that can create warm, humid, macerating environments where dermatophytes thrive.

Treatment

Tinea pedis can be treated with topical or oral antifungals or a combination of both. Topical agents are to be used for 1-6 wk depending on manufacturer's recommendation. Patients with moccasin type tinea pedis should have medication applied to the bottom and sides the affected foot. For interdigital tinea pedis, the topical agent should be applied to interdigital areas and soles because of the likelyhod that the dermatophyte has infected the plantar surface, even though symptoms may not be present.
Extensive moccasin tinea pedis or inflammatory (bullous) tinea pedis usually requires oral therapy, as do patients with onychomycosis, diabetics, immunocompromised patients, or patients with peripheral vascular disease.

Topical agents

To be applied twice daily.
Clean and thoroughly dry the affected areas.
Apply to the affected skin and surrounding area in a thin layer and rub it in lightly.
Wash hands after applying the medication.
Duration of treatment should be >1 wk but not >4 wk.
Apply sparingly to avoid maceration effects.

Clotrimazole (Mycelex, Lotrimin) -- 1%.

Miconazole (Monistat) 2% lotion

Terbinafine (Lamisil) – 1% cream

Oral agents:

Itraconazole (Sporanox) -- 200 mg PO daily for 1 wk; not to exceed 400 mg/d; increase in 100-mg increments if no improvement (administer >200 mg/d in divided doses)
Monitor hepatic function in patients taking itraconazole for >1 mo, and who develop any sign of hepatic insufficiencies

Terbinafine (Lamisil) -- 250 mg PO daily for 1-2 wk.
Perform hepatic function tests and CBCs when taking for >6 wk, develop signs of hepatic dysfunction, or are immunocompromised; not recommended for pre-existing liver disease or renal impairment

Refs:
Palin, Diana; Tinea Pedis; fohwcb.uws.edu.au/podiatry/tinea.htm 2/26/2003
Martin, Elizabeth S., Tinea Pedis, http://www.emedicine.com/derm/topic470.htm
/26/2003

Written: 4/03
Revised: 01/08

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
INFECTION CONTROL

Chapter Fourteen

Risk Assessment And Goals For FY 2007-2008

RISK ASSESSMENT:

By seriousness or volume, the Institute's risk of infectious disease problems is prioritized as follows:

1) Food borne illness

2) Person-to-person transmission of blood-borne illness.

3) Person-to-person transmission of influenza-like illness.

4) Person-to-person transmission of fungal skin infection.

5) Water-borne illness.

6) Respiratory fungal infection.

7) Person-to-person transmission of pulmonary tuberculosis

8) Person-to-person transmission of Methicillin Resistant Staph Aureus skin infections.

GOALS:

1. Reduce healthcare-acquired infections.
2. Manage the severity of a bioterrorism attack.
3. Manage the risk of a pandemic influenza.
4. Reduce environmental infection risks.

RISKS, OBJECTIVES, AND MEASURES OF SUCCESS

RISK	OBJECTIVE	STRATEGY	MEASUREMENT	LEAD STAFF	OTHER STA
All infections	Increase hand hygiene compliance	• Direct observation monitoring. • Monitor use of hand hygiene supplies.	• Observation of 10 processes Q month • Volume of hand gel used.	• Clinical managers • Food service manager • Environmental Services	• Clinical sta • Food Servi staff • Environme Services sta

		• Improved education		manager	
Food borne illness	Reduce the risk of a gastroenteritis outbreak.	• Appropriate food management. • Timeliness of tray delivery. • Patient food on nursing units follows SVMHI policy and regulations.	• Daily logs of Food Service rounds. • Monitoring of timeliness of 10 patient's trays/month • Quarterly infection control rounds for food in patient rooms.	• Food service manager • Environmental Services manager • Food Service manager • Nurse Managers	• Food Servic staff • Environmen Services staf • Patient care team membe
Person-to-person transmission of blood-borne illness.	Prevention of transmission of blood-borne illness.	• Use of Standard Precautions. • Rapid testing for HIV, HVB, HVC	• Monitoring of needlestick injuries. • Monitoring of staff and patient skin penetrations.	• Registered nurses • Medical Staff • IC program manager.	• Clinical staf
Person-to-person transmission of influenza-like illness.	Prevention of transmission of influenza-like illnesses	• Influenza vaccinations. • Testing for Influenza • Identify and monitor at risk patients.	• Monitor vaccine given. • Record of influenza testing for symptomatic patients. • Documentation of patients at risk .	• Medical Staff • All mangers. • IC program manager	• All staff. • Pharmacist • Family Nur Practitioner
Person-to-person transmission of fungal skin infection.	Prevention of transmission of fungal foot infections	• Use of bath footwear. • Aggressive cleaning of showers/baths • Use of fungal infection protocol.	• Monitoring of use of bath footwear. • Review of cleaning records. • Record review for compliance with fungal infection protocol.	• IC Program Manager • Medical Staff • Registered nurses.	• Environme Services st • Patient car team memb
Water-borne respiratory illness.	Prevention of acquisition of water-borne pneumonia	• Implementation of legionella prevention plan.	• Monitoring of Implementation of legionella prevention plan	• Physical Plant staff • IC Program Manager	• Physical P staff.

			• Surveillance of pneumonic illnesses		
Respiratory fungal infection.	Prevention of acquisition of respiratory fungal infection	• Replacement of water logged ceiling tiles. • Respirator use when working in false ceiling areas • Correction of damp conditions.	• Monitoring of ceiling tiles. • Monitoring of the use of respiratory protection. • Periodic environmental surveillance.	• Physical Plant Manager • IC Program Manager.	• Physical Pla staff.
Person-to-person transmission of pulmonary tuberculosis	Prevention of transmission of pulmonary tuberculosis	• Implementation of employee TB prevention plan. • Rapid referral of sero-convertors	• Monitoring of Mantoux tests given. • Record review for application of risk-factor identification.	• IC Program Manager • Medical Staff • Registered nurses. • HR manager	• All clinical staff • HR staff.
Person-to-person transmission of Methicillin Resistant Staph Aureus skin infections	Prevention of transmission of Methicillin Resistant Staph Aureus skin infections	• Use of Standard Precautions. • Rapid testing for MRSA • Appropriate use of antimicrobials.	• Monitor dressing technique. • Monitor patient compliance with hygiene practices. • Review of culture and sensitivity studies.	• IC Program Manager • Medical Staff • Registered nurses.	• All clinical staff. • Pharmacist
Emergency preparedness	• Pandemic Influenza. • Bioterrorism.	• Review and revision of the Bioterrorism and Pandemic Influenza Plans as needed. • Training for IC Emergency Preparedness. • Drills and exercises.	• Review dates • Training records and IC training goals/objectives • Documentation of drills and exercises.	• Infection Control Program Manager . • Infection Control Committee members. • Senior Management Team.	• All SVMH staff

KINCAID ◆ BRYANT

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A professional corporation

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Phone: 434-846-6510 • Fax: 434-385-9059

Project Code: 720-10880-39-03
Client: Southern VA Mental Health Kitchen Replacement

Commission No: 07090

DOCUMENT HOLDERS LIST

SET NO.	FIRM NAME & ADDRESS	CONTACT	PHONE	FAX	DEPOSIT	SHIPPING CHARGE	DATE RECEIVED	DATE RETURNED	REMARKS
1	Kincaid-Bryant								
2	McGraw-Hill Construction - 9 North Third Street - Richmond, VA 23219		804-373-2034	804-373-2701			14-Jan-08		
3	Builders Exchange, Inc. - 3207 Hermitage Road - Richmond, VA 23227		804-353-2788	804-353-8640			14-Jan-08		
4	Valley Construction News - 308 Turner Road, Suite D - Richmond, VA 23225		804-674-0118	804-~~74~~ 674-0397			14-Jan-08		
5	McGraw-Hill Construction - 5815-B Airport Road - Roanoke, VA 24012		540-265-1375	540-265-1376			14-Jan-08		
6	1 Sq Ft Planroom - 6403-B Dickens Place Richmond, VA 23230		828-390-7090	1-866-570-8187			15-Jan-08		
7	DMHMRSAS - 1220 Bank Street, Rm 731 Richmond, VA 23219	Jim Taylor	804-371-0314	804-371-8898		hand delivered by David Kincaid	15-Jan-08		
8	Southern VA Mental Health - 382 Taylor Drive Danville, VA 24541	Buddy Sigmon	434-799-6220	434-773-4262			15-Jan-08		
9	1 Sq Ft Planroom - 709 Middle Ground Blvd. Ste A-110 Newport News, VA 23606	Paul Tilford	828-390-7090	866-570-8187			16-Jan-08	21-Jan-08	
10	Tune & Toler, Inc. 10432 US Hwy 29N Blairs, VA 24527		434-836-5100	434-836-7633	$100.00	$15.00	24-Jan-08		

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11	Reed Construction Data - 30 Technology Pkwy So. Ste 500 - Norcross, GA 30092		800-825-541	800-303-8629	$100.00	$15.00	25-Jan-08		
12	DMHRSAS - 5525 Catawba Hospital Drive Catawba, VA 24070	Mike Cash	540-375-4710	540-375-4701		hand delivered by David Kincaid	28-Jan-08		
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